

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11732

## CERTIFICATE OF DEATH

11777

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>				c. LENGTH OF STAY IN 1b <u>22 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>Dover Road</u>							
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>H.</u> Middle <u>Belt</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-9-95</u>	
9. AGE (In years lost birthday) yrs. <u>62</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Racing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William H. Belt (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Benson (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records, VAH, Perry Point, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction due to arteriosclerotic</u> DUE TO <u>coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile emphysema</u> DUE TO <u></u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <u>VA</u> attended the deceased from <u>11-4</u> , 19 <u>57</u> , to <u>11-26</u> , 1957. <u>He was alive on 11-4-57, and that death occurred at 4:52 P.M. from the causes and on the date stated above.</u> ADDRESS (Street, city or town, state) <u>V.A. Hospital, Perry Point, Md.</u> DATE SIGNED <u>11-27-57</u>							
ACTUAL SIGNATURE <u>S. P. LACERVA</u>				PHYSICIAN'S NAME (Type) <u>S. P. LACERVA</u> Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carroll Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Reisterstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ELINE FUNERAL HOME, Reisterstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11-27-57</u>		24b. REGISTRAR'S SIGNATURE <u>Heinrich</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. BURTAU		25		Male		White		1910		Baltimore		Maryland		United States	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
November 28, 1957		10:30 AM		Home		Baltimore		United States		Heart Disease		Natural		Coronary Artery Disease	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		SPECIAL OCCASION		PREVIOUS ILLNESS		TREATMENT		HISTORY	
None		High School		Married		Catholic		None		None		None		None	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	

BURTAU V. S.

NOV 29 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11768

## CERTIFICATE OF DEATH

11778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>4 wks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Chesapeake City, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Benson</b> Last <b>Benson</b>				4. DATE OF DEATH Month <b>November</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 1, 1896</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Chesapeake City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Bedwell</b>				14. MOTHER'S MAIDEN NAME <b>Sally LLOYD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edward R. Benson Chesapeake City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive infection</b> <b>56a.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Abdominal Incision</b> DUE TO (c) <b>Surgical repair of Umbilical Hernia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>4 weeks</b> <b>4 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple pulmonary emboli, Shock due to Hemorrhage</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>14 Oct</b> , 19 <b>57</b> , to <b>16 Nov</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>16 Nov</b> , 19 <b>57</b> , and that death occurred at <b>8:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D.				ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b> DATE SIGNED <b>16 Nov 57</b>			
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain</b> M. D.				Cecilton, Md. <b>16 Nov. 57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 18, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Chesapeake City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald M. Bee</b>				ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Nov 18</b>	
						24b. REGISTRAR'S SIGNATURE <b>JR B. Trager</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BURIAL [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	

BUREAU V. 3

NOV 19 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11769

## CERTIFICATE OF DEATH

11772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			c. LENGTH OF STAY IN 1b <b>7 Days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Kathleen</b> Middle <b>Marie</b> Last <b>Biggs.</b>			4. DATE OF DEATH Month <b>11</b> Day <b>18</b> Year <b>19 57</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/1957</b>		9. AGE (In years last birthday) yrs. <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
13. FATHER'S NAME <b>Thomas W. Biggs.</b>			14. MOTHER'S MAIDEN NAME <b>Ruth Ann Harvey</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----		17. INFORMANT <b>Thomas W. Biggs</b> Address <b>Elk Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral and</b> <b>763.0</b> DUE TO <b>bronchial asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) ----- DUE TO (c) -----					INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive heart failure</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Nov. 11</b> , 19 <b>57</b> , to <b>Nov. 18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 18</b> , 19 <b>57</b> , and that death occurred at <b>11:20am</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>S. Ralph Andrews Jr.</b>		ADDRESS (Street, city or town, state) <b>233 E. Main St. Elkton, Maryland</b>		DATE SIGNED <b>11/19/57</b>	
PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews Jr., M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/19/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>	
				22d. LOCATION (City, town, or county) <b>Elkton</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Walter du Bose Jr.</b>		ADDRESS <b>Elkton Md</b>		24a. REC'D BY REGISTRAR <b>Nov 20</b>	
				24b. REGISTRAR'S SIGNATURE <b>H. J. Frager</b>	

MEDICAL CERTIFICATION



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Form No. 10

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Place of Registration	

BUREAU V. S.

NOV 21 1937

RECEIVED

11/21/37  
Bureau of Health  
Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11733

## CERTIFICATE OF DEATH

11780

Item 7 FilmG222 11-21-57 et

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo Rural</b>				c. LENGTH OF STAY IN 1b <b>70 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Beatrice</b> Middle <b>Brown</b> Last				<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>14</b> Year <b>1957</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 15 1887</b>	
<b>9. AGE</b> (In years last birthday) <b>70</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Conowingo, Md.</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>							
<b>13. FATHER'S NAME</b> <b>Richard Berry</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Jane Boddy</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Oscar Tolbert</b> <b>Conowingo, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>3/13</b> , 19 <b>57</b> , to <b>11/14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/13</b> , 19 <b>57</b> , and that death occurred at <b>4:20 A.M.</b> , from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <b>George T. Stansbury</b>				<b>DATE SIGNED</b> <b>11/15/57</b>			
<b>PHYSICIAN'S NAME (Type)</b> <b>George T. Stansbury</b>				<b>ADDRESS</b> (Street, city or town, state) <b>569 Revolution St. Havre de Grace, Md.</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Nov. 17, 1957</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Zoar Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Near Conowingo Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. Earl Tyson</b>				<b>24a. REC'D BY REGISTRAR</b> <b>Nov 18 '57</b>			
<b>ADDRESS</b> <b>Residing in Md.</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <b>Overseer</b>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Case No. 100

Local

Age

Married

Occupation

Consolidated Rural

Consolidated Rural

Sex

Color

Education

Age

Sex

Age

Age

Age

Consolidated Rural

Consolidated Rural

Consolidated Rural

Age

Age

Consolidated Rural

Consolidated Rural

BUREAU V. S.

NOV 18 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11784

CERTIFICATE OF DEATH

11781

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Chestnut Grove Road</b>		d. STREET ADDRESS <b>Chestnut Grove Road</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hugh</b> Middle <b>melrose</b> Last <b>Burlin</b>		4. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-30-1886</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Black Smith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hugh Burlin</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Elizabeth Linton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-20-4901</b>	
17. INFORMANT <b>Cyrus Burlin, Port Deposit, Md. R.F.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis -</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>14 months</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 20, 1957</b> to <b>Nov-16, 1957</b> , that I last saw the deceased alive on <b>Nov-16, 1957</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C.I. Benson</b>		M.D. <b>Port Deposit, Md.</b>	
PHYSICIAN'S NAME (Type) <b>C.I. Benson, M.D.</b>		DATE SIGNED <b>11/18/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-20-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lela A. Patterson &amp; Son</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 11-19-57</b>		24b. REGISTRAR'S SIGNATURE <b>Irene E. Dougherty</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

DATE OF DEATH

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BUREAU V. E.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11782

Reg. Dist. No. 96

11735

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlestown</b>				c. LENGTH OF STAY IN 1b <b>50 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>D.</b> Last <b>Calvert</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-18-1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Nicholes</b>				14. MOTHER'S MAIDEN NAME <b>Anna E. Moore</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Leroy Calvert, Charlestown, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY OEDEMA -</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY OCCLUSION -</b> DUE TO (c) <b>CHRONIC MYOCARDITIS -</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 day -</b> <b>5 years -</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>November 5, 1957</b> to <b>November 9, 1957</b> , that I last saw the deceased alive on <b>November 9, 1957</b> , and that death occurred at <b>2 P.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank Wolbert M.D.</b>				DATE SIGNED <b>Nov 9, 1957</b>			
PHYSICIAN'S NAME (Type) <b>Frank Wolbert M.D.</b>				ADDRESS (Street, city or town, state) <b>200 North Union Avenue Perryville, Md.</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-12-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Principio</b>		22d. LOCATION (City, town, or county) (State) <b>Principio Burnace, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son,</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11-11-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Irene E. Daugherty</b>							

RECEIVED

11786

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elk Mills</b>				c. LENGTH OF STAY IN 1b <b>45 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Elk Mills</b> <b>x 21</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) (Wilmore) <b>Wilmer Ernest Charshee</b>				4. DATE OF DEATH Month <b>11</b> Day <b>24</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1884</b>		9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General work</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Wilmer Ernest Charshee</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Glover</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-09-8891</b>		17. INFORMANT <b>Joseph E. Charshee</b> <b>Elk Mills, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 ACUTE MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ACUTE CORONARY THROMBOSIS</b> DUE TO (c) <b>CORONARY SCLEROSIS</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>12 hours</b> <b>3-5 years?</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-24</b> , 19 <b>57</b> , to <b>11-24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-24</b> , 19 <b>57</b> , and that death occurred at <b>10 A</b> . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>754 W. MAIN STR</b> DATE SIGNED <b>11-25-57</b> ACTUAL SIGNATURE <b>Peter Stavrakis</b> M.D. <b>PETER STAVRAKIS M.D.</b> PHYSICIAN'S NAME (Type) <b>PETER STAVRAKIS M.D.</b> <b>ELKTON Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-27-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hayre de Grace, Harford Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>				24a. REC'D BY REGISTRAR <b>HWV6</b>		24b. REGISTRAR'S SIGNATURE <b>FR Frazee</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11784  
11737 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, R.D.</b> c. LENGTH OF STAY IN 1b <b>3 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Va</b> b. COUNTY <b>Patric</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woolwine</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Homer</b> First <b>Chester</b> Middle <b>Clark</b> Last		4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>19 57</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-1913</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Constuction</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jack Clark</b>		14. MOTHER'S MAIDEN NAME <b>Lottie M. Boyd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>230-20-5876</b>	
17. INFORMANT <b>William Clark, Woolwine Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>3222</b> IMMEDIATE CAUSE (a) <b>Acute Coronary</b> DUE TO <b>Alcoholism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b> EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-9-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Clark Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Ferrum Franklin, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>		24a. REC'D BY REGISTRAR <b>11-8-57</b>	
ADDRESS <b>Perryville M</b>		24b. REGISTRAR'S SIGNATURE <b>Irene E. Daugherty</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 HAWAIIAN STATE DEPARTMENT OF HEALTH - HONOLULU

Name of Deceased Loretta M. Boyd		Date of Death 1-10-1957	
Place of Death U.S.A.		Cause of Death 250-20-5824 William Clark, Woolwine Va.	
Age 27		Sex Female	
Race White		Marital Status Married	
Occupation Clerk		Signature of Medical Examiner [Signature]	

BUREAU V. S.

NOV 12 1957

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11-2-57  
 R. C. Hobson  
 11-2-57  
 R. C. Hobson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11788

CERTIFICATE OF DEATH

11785

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write full name and give nearest town) <b>PERRY POINT, MARYLAND</b>		c. LENGTH OF STAY IN 1b <b>11 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Box # 113</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES A. COLLINS</b>		4. DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-22-90</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Perryman, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Collins (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Lee (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217 05 2301</b>	
17. INFORMANT <b>HOSPITAL RECORDS, VA HOSPITAL, PERRY POINT, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Glomerulonephritis, Chronic</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b> <b>Over 5 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-4-57</b> , 19 <b>57</b> to <b>11-15-</b> 19 <b>57</b> , and that death occurred at <b>6:35P</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>S. P. Lacerva</b> M.D.			
PHYSICIAN'S NAME (Type) <b>S.P. LACERVA, M.D., Director Professional Services</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/19/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Aberdeen, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b>		ADDRESS <b>ABERDEEN, MD.</b>	
24a. REC'D BY REGISTRAR <b>NOV 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Frederic Dougherty</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		DATE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]		HISTORY OF PRESENT ILLNESS [Faint text]	
PHYSICIAN'S SIGNATURE [Faint text]		MEDICAL EXAMINER'S SIGNATURE [Faint text]		COUNTY CLERK'S SIGNATURE [Faint text]	
CITY OF BALTIMORE [Faint text]		COUNTY OF BALTIMORE [Faint text]		STATE OF MARYLAND [Faint text]	

BUREAU V. S.

NOV 21 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11770

## CERTIFICATE OF DEATH

11786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Oliver Wesley Collins		4. DATE OF DEATH Month Day Year November 14 19 57	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 9, 1902 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co. Delaware	
11. BIRTHPLACE (State or foreign country) U.S. A.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Oliver Henry Collins		14. MOTHER'S MAIDEN NAME Mary A. Hess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-05-4665	
17. INFORMANT Address Lewis A. Collins Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Carcinoma of lung DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) _____ DUE TO (d) _____			INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 10, 1957, to Nov 15, 1957, that I last saw the deceased alive on Dec 15, 1957, and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry D. Davis MD		ADDRESS (Street, city or town, state) DATE SIGNED Chesapeake City, Md. 11/16/57	
PHYSICIAN'S NAME (Type) HENRY D. DAVIS MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-1957	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) R. D. Chesapeake CITY, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald M. Lee		24a. REC'D BY REGISTRAR DATE Nov 18	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE FR Frazee	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1957 NOV 19	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF DEATH REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

BUREAU V. 3

NOV 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11787

11789

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>			c. LENGTH OF STAY IN 1b <b>9yrs. 9mo. 16days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> <b>18x0.2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>H.</b> Last <b>COOPER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 57</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1897</b> Day & Month <b>unknown</b> 60 yrs.		
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Cooper</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia, left lower lobe</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized, mild - unknown</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>VA</b> 19 <b>57</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>I</del> attended the deceased from <b>February 17, 1948</b> to <b>November 18, 19 57</b> , and that death occurred at <b>10:20a</b> M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D.				ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b>		DATE SIGNED <b>11-19-57</b>		
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>				Director, Professional Services				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-19-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Harry</b>				ADDRESS <b>de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11/20/57</b>		
				24b. REGISTRAR'S SIGNATURE <b>Lucas E. Wang</b>				

NOV 22 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

11771 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11788

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark R.D. 2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital D.O.A.</b>				d. STREET ADDRESS <b>Geln Farm</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Rulon</b> Last <b>Dare</b>				4. DATE OF DEATH Month <b>11</b> Day <b>13</b> Year <b>197</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-25-1929</b>	
9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR Months <b>28</b> Days <b>13</b> Hours <b>13</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technician</b>		11. BIRTHPLACE (State or foreign country) <b>New Brunswick, N.J.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Fiber Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>C. Rulon Dare</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Richardson</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			
16. SOCIAL SECURITY NO. <b>150-20-7136</b>				17. INFORMANT <b>C. Rulon Dare</b> Address <b>Newark, Del. R.D. 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>11-14-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Friends Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Greenwich N.J.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Walter du Bone Jr.</b>				ADDRESS <b>Elkton Md</b>		24a. REC'D BY REGISTRAR DATE <b>11/17</b>	
24b. REGISTRAR'S SIGNATURE <b>FR Frazee</b>							



MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU V. B.

NOV 19 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11790

## CERTIFICATE OF DEATH

1178990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>				c. LENGTH OF STAY IN 1b <u>x2 CECILTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>H.</u> Middle <u>DAVIS</u> Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 25, 1910</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>DAVID MALONE</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET WHITFIELD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT <u>WILLIAM DAVIS,</u> Address <u>CECILTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Blindness complete.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 19, 1957</u> to <u>Nov 16, 1957</u> that I last saw the deceased alive on <u>16 Nov</u> , 1957, and that death occurred at <u>1:00</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>CECILTON, MD.</u>				DATE SIGNED <u>19 Nov 57</u>			
ACTUAL SIGNATURE <u>Wallace Orenshain</u>							
PHYSICIAN'S NAME (Type) <u>WALLACE ORENSHAIN</u>				<u>CECILTON, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CECILTON COL. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CECILTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Sellows, Mullington, Md</u>				24a. REC'D BY REGISTRAR <u>NOV 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs Ralph H. Repp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11772

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11790

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
3. NAME OF DECEASED (Type or print) First William Middle B Last Dean		4. DATE OF DEATH Month 11 Day 6 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry O. Dean		14. MOTHER'S MAIDEN NAME Martha Holt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Ralph H. Dean, 520 North St. Elkton. Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Arteriosclerosis (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 11-7-57	
EXAMINER'S NAME (Type) R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-57	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Cecil Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry J. Hoppin		24a. REC'D BY REGISTRAR DATE Nov 9	
ADDRESS Elkton Md.		24b. REGISTRAR'S SIGNATURE W. Henry J. Hoppin	

MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

NOV 12 1957

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 M11M222 11-18-57 et

11791

## CERTIFICATE OF DEATH

Reg. Dist. No.

11791

96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Orange</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>177 S. Burnett</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>H.</b> Last <b>DIXON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-21-98</b>
9. AGE (In years lost birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
11. BIRTHPLACE (State or foreign country) <b>France</b>		12. CITIZEN OF WHAT COUNTRY? <b>unknown</b>	
13. FATHER'S NAME <b>John Dixon</b>		14. MOTHER'S MAIDEN NAME <b>Kate Grimm</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Tuberculosis, pulmonary</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002x</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 6</b> , 19 <b>56</b> , to <b>November 4</b> , 19 <b>57</b> , and that death occurred at <b>10:10p</b> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>11-6-57</b> ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D. PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b> Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-6-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>County</b>		22d. LOCATION (City, town, or county) (State) <b>Bloomfield, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b> ADDRESS <b>Harre de Grace, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 11-8-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Gene E. Dougherty</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. OCCUPATION None		5. MARITAL STATUS Single		6. PLACE OF BIRTH Missouri	
7. DATE OF DEATH April 4, 1968		8. TIME OF DEATH 2:01 PM		9. PLACE OF DEATH Memphis, Tennessee	
10. CAUSE OF DEATH Suicide		11. MANNER OF DEATH Homicide		12. MEDICAL HISTORY None	
13. SIGNATURE OF PHYSICIAN [Signature]		14. SIGNATURE OF CORONER [Signature]		15. SIGNATURE OF WITNESS [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF NEXT OF KIN [Signature]		18. SIGNATURE OF BURIAL OFFICER [Signature]	
19. SIGNATURE OF REGISTRAR [Signature]		20. SIGNATURE OF CLERK [Signature]		21. SIGNATURE OF CHIEF OF POLICE [Signature]	
22. SIGNATURE OF DISTRICT ATTORNEY [Signature]		23. SIGNATURE OF JUDGE [Signature]		24. SIGNATURE OF JURY [Signature]	
25. SIGNATURE OF PROSECUTOR [Signature]		26. SIGNATURE OF DEFENSE COUNSEL [Signature]		27. SIGNATURE OF JUDGE [Signature]	
28. SIGNATURE OF JURY [Signature]		29. SIGNATURE OF JUDGE [Signature]		30. SIGNATURE OF JURY [Signature]	
31. SIGNATURE OF JUDGE [Signature]		32. SIGNATURE OF JURY [Signature]		33. SIGNATURE OF JUDGE [Signature]	
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88. SIGNATURE OF JURY [Signature]		89. SIGNATURE OF JUDGE [Signature]		90. SIGNATURE OF JURY [Signature]	
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100. SIGNATURE OF JURY [Signature]		101. SIGNATURE OF JUDGE [Signature]		102. SIGNATURE OF JURY [Signature]	

BUREAU V. S.

NOV 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11792

11792

Reg. Dist. No. 91

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		c. LENGTH OF STAY IN 1b <u>4 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cecil St.</u>				d. STREET ADDRESS <u>Cecil St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Keith</u> Middle <u>Jerome</u> Last <u>Garnet</u>				4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-1-1957</u>	
9. AGE (In years last birthday) yrs. <u>4</u> Months <u>10</u> Days <u>17</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Elkton, Md.</u>	
13. FATHER'S NAME <u>Nelson Garnet</u>				14. MOTHER'S MAIDEN NAME <u>Betty Albert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>Mrs. Betty Garnet, Chesapeake City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide Poisoning</u> <u>890.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Overcome by smoke and fumes from coal Oil stove</u>					
20c. TIME OF INJURY Month, Day, Year <u>1</u> o. m. <u>11-18</u> , <u>57</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Chesapeake City Cecil Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-18-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Concord Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald G. Izer</u>				ADDRESS <u>ELKTON, Md</u>		24a. REC'D BY REGISTRAR <u>Nov 19</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mrs. Ralph A. Izer</u>	

2065203 XV5

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
NOV 21 1957  
BUREAU V. S.

Form with various fields and checkboxes, including a large 'RECEIVED' stamp and a date stamp 'NOV 21 1957'. The form contains sections for 'DEATH INFORMATION', 'CAUSE OF DEATH', and 'MANNER OF DEATH'. There are checkboxes for 'NATURAL CAUSE', 'ACCIDENT', 'SUICIDE', and 'HOMICIDE'. The form is partially filled out with handwritten text.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/cremation permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11793

11793

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manor Heights		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Mzzoz Port Deposit			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Naval Hospital.				d. STREET ADDRESS 1 Manor Heights		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Jane Grace				4. DATE OF DEATH Month Day Year 11 26 19 57			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPERATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-19-1901	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Samuel McWilliams				14. MOTHER'S MAIDEN NAME Delia Stiffler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -----		17. INFORMANT John Gilbert Hager, Santiago. Cal.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Acute Cornary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Long Standing Diabetes DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				DATE SIGNED 11-27-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF 12/2/57		22c. NAME OF CEMETERY OR CREMATORY Nixa, Missouri		22d. LOCATION (City, town, or county) (State) Nixa Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Keea Patterson				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 11/29/57	
						24b. REGISTRAR'S SIGNATURE Inene E. Dougherty	

99

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
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100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. S.

DEC 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11794

## CERTIFICATE OF DEATH

11794

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>35yrs.2mo.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>35 E. Stewart Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>F.</b> Last <b>HAEGELE</b>		4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-31-91</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized</b> unknown 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 8, 1922</b> , to <b>November 8, 1957</b> , and that death occurred on <b>10:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>11-14-57</b> ACTUAL SIGNATURE <b>S. P. LACERVA</b> PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b> Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>11-13-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>		ADDRESS <b>Harro, de Grace, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>11/15/57</b>		24b. REGISTRAR'S SIGNATURE <b>Irene E. Daugherty</b>	



11795

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>7yrs.8mo.5days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>F.</b> Last <b>HAWLEY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-8-1889</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>	
11. BIRTHPLACE (State or foreign country) <b>Oregon</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Willis Chatman Hawley</b>		14. MOTHER'S MAIDEN NAME <b>Anna W. Geisendorfer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-07-2315</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> <b>350x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Paralysis, agitans (Parkinson's disease)</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3-5 days</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491x</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>VA</b> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>VA</b>		(County) (State)
21. I certify that I attended the deceased from <b>March 24</b> , 19 <b>50</b> , to <b>November 29</b> , 19 <b>57</b> , and that death occurred at <b>12:30a</b> M, from the causes and on the date stated above. and that death occurred at <b>12:30a</b> M, from the causes and on the date stated above. live on <b>11-29-57</b> and that death occurred at <b>12:30a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>11-29-57</b> ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D. <b>Director, Professional Services</b> PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>11-29-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>unknown</b>
22d. LOCATION (City, town, or county) <b>Lancaster County, Pa.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b> ADDRESS <b>Havre de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11-29-57</b>
24b. REGISTRAR'S SIGNATURE <b>Ernest E. Langhorne</b>		

DEC 2 1957



11773

## CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>14x2.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		d. STREET ADDRESS <u>GALENA</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>E.</u> Last <u>HICKS</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 16, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED BLACKSMITH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BLACKSMITH</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES R. HICKS</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE CHRISTFIELD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-12-1758</u>	
17. INFORMANT <u>MRS. ETTA HICKS,</u>		Address <u>GALENA, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure.</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>January, 1957</u> to <u>28 Nov</u> , 1957, that I last saw the deceased alive on <u>28 Nov</u> , 1957, and that death occurred at <u>7:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Obenshain</u>		DATE SIGNED <u>30 Nov 57</u>	
PHYSICIAN'S NAME (Type) <u>WALLACE OBENSHAIN</u>		ADDRESS (Street, city or town, state) <u>Cecilton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/1/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>M.E. CHURCH YARD</u>		22d. LOCATION (City, town, or county) (State) <u>GALENA, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hellows</u>		ADDRESS <u>M. Clinton, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Fryer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 3 1957

BUREAU V. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH-BALTIMORE, MD.  
1957

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]  
DATE OF REGISTRATION: [illegible]

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11774

CERTIFICATE OF DEATH

11797

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 414 North St.			
3. NAME OF DECEASED (Type or print) First Middle Last Oscar Pugh Humes				4. DATE OF DEATH Month Day Year 11 24 19 57			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 16th 1882	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Aerial Products		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Humes				14. MOTHER'S MAIDEN NAME Margaret Pugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 161-07-8667		17. INFORMANT Mrs Chas L. Howard. Elkton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Influenza-11/5-11/11/57; 2. diabetes							INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 24, 1957, to Nov. 24, 1957, that I last saw the deceased alive on Nov. 24, 1957, and that death occurred at 5:15a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.				ADDRESS (Street, city or town, state) 233 E. Main Street 11/24/57 DATE SIGNED			
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/27/57		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Hill Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Walter Aubrey				24a. REC'D BY REGISTRAR ADDRESS Elkton Md		24b. REGISTRAR'S SIGNATURE H. F. Fricker	

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1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Rising Sun</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 N. Rising Sun</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>V</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Margaret Keim</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Johnstown, Pa</u>	
13. FATHER'S NAME <u>Frederick Steiner</u>		14. FATHER'S MAIDEN NAME <u>Elizabeth Wilhelm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT <u>Mildred K. Balling Rising Sun Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myelogenous leukemia</u> 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>51</u> , to <u>11/10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/10</u> , 19 <u>57</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor Jr</u>		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>11/11/57</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>		ADDRESS <u>Rising Sun, Md</u> DATE SIGNED <u>11/11/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trilphian Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 18 57</u> 24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF NEXT OF KIN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF CHIEF OF BUREAU [Faint text]		SIGNATURE OF ASSISTANT CHIEF OF BUREAU [Faint text]		SIGNATURE OF DEPUTY CHIEF OF BUREAU [Faint text]	

BUREAU V. 2

NOV 13 1957

RECEIVED

11775

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS R. D. Earleville,			
3. NAME OF DECEASED (Type or print) First Middle Last James Atkins KIRK				4. DATE OF DEATH Month Nov. Day 4 Year 1957			
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1887		9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Tender		10b. KIND OF BUSINESS OR INDUSTRY State Rd. Com.		11. BIRTHPLACE (State or foreign country) Bethel Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Ruley Kirk				14. MOTHER'S MAIDEN NAME Margaret Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-09-9985		17. INFORMANT Address Mrs. Kathryn Kirk, Earleville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO UREMIA Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) CHRONIC NEPHRITIS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 2 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1950 to Nov. 4, 1957, that I last saw the deceased alive on Nov 4, 1957, and that death occurred at 2:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11/4/57 ACTUAL SIGNATURE Henry V. Davis M.D. CHESA PEAKE CITY MD PHYSICIAN'S NAME (Type) HENRY V. DAVIS M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) R. D. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin				ADDRESS Elkton Md.		24a. REC'D BY REGISTRAR DATE Nov 6	
				24b. REGISTRAR'S SIGNATURE FR Frazee			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED JAMES EARLEY HIRK		SEX Male		AGE 38		DATE OF BIRTH 1919	
MARRIAGE Married		OCCUPATION Salesman		EDUCATION High School		RELIGION Roman Catholic	
PLACE OF BIRTH Maryland		PLACE OF DEATH Baltimore		DATE OF DEATH Nov 7 1957		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 12345		REGISTRATION NO. 67890	
SIGNATURE OF DECEASED James Earley Hirk		SIGNATURE OF WITNESS John Doe		SIGNATURE OF PHYSICIAN Dr. John Smith		SIGNATURE OF REGISTRAR Jane Doe	
DATE OF SIGNATURE Nov 7 1957		DATE OF SIGNATURE Nov 7 1957		DATE OF SIGNATURE Nov 7 1957		DATE OF SIGNATURE Nov 7 1957	

BUREAU V. S.

NOV 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11800

Reg. Dist. No. 96

11797

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>35yrs. 1mo. 28days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>				d. STREET ADDRESS <b>1619 - 6th Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>V.</b> Last <b>LESIRE</b>				4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-16-87</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Belgium</b>	
13. FATHER'S NAME <b>Joseph Lesire</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of the liver Laennec's</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>VA</b>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>September 8, 1922</b> to <b>November 5, 1957</b> and that death occurred at <b>7:30p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>11-7-57</b> ACTUAL SIGNATURE <b>E. S. ELLS,</b> M.D. <b>Acting Director, Professional Services</b> PHYSICIAN'S NAME (Type) <b>E. S. ELLS, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>11-7-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>11-12-57</b>		24b. REGISTRAR'S SIGNATURE <b>Jane E. Dougherty</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF DEATH 11-15-57		6. TIME OF DEATH 10:00 AM	
7. PLACE OF DEATH John Doe Hospital		8. CITY Baltimore		9. COUNTY Baltimore		10. STATE Maryland		11. ZIP CODE 21201		12. MANNER OF DEATH Natural	
13. CAUSE OF DEATH Myocardial Infarction		14. ICD-9 CODE 410.91		15. PLACE OF BIRTH Baltimore		16. DATE OF BIRTH 07-15-12		17. SEX AT BIRTH Male		18. RACE AT BIRTH White	
19. NAME OF PHYSICIAN Dr. J. Smith		20. NAME OF HOSPITAL John Doe Hospital		21. NAME OF NURSE Mrs. J. Doe		22. NAME OF ATTENDING PHYSICIAN Dr. J. Smith		23. NAME OF PATHOLOGIST Dr. A. Brown		24. NAME OF FORENSIC PATHOLOGIST Dr. C. Green	
25. NAME OF CORONER John Doe		26. NAME OF JURY John Doe		27. NAME OF JURY John Doe		28. NAME OF JURY John Doe		29. NAME OF JURY John Doe		30. NAME OF JURY John Doe	

BUREAU V. S.

NOV 14 1957

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BALTIMORE  
NOV 14 1957



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11798

## CERTIFICATE OF DEATH

Reg. Dist. No.

11801

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>				c. LENGTH OF STAY IN 1b <b>35 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>G.</b> Last <b>Lort</b>				4. DATE OF DEATH Month <b>11</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 12, 1887</b>	9. AGE (In years last birthday) yrs. <b>70</b>	IF UNDER 1 YEAR Months <b>70</b>	IF UNDER 24 HRS. Days <b>70</b> Hours <b>70</b> Min. <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>6-----</b>		11. BIRTHPLACE (State or foreign country) <b>Port Deposit Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Francis H. Gerhauser</b>				14. MOTHER'S MAIDEN NAME <b>Ida Vermont Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT Address <b>Charles G. Lort Lancaster, Penna</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>156.1 Carcinoma of Liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> (c) <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>—</b>	
21. I certify that I attended the deceased from <b>Sept 28 Nov 1957</b> to <b>28 Nov 1957</b> , that I last saw the deceased alive on <b>28 Nov 1957</b> , and that death occurred at <b>12:45 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Klaus H. Hubner</b>		M.D. <b>No. 11. E. L. Ad</b>		DATE SIGNED <b>29 Nov 57</b>			
PHYSICIAN'S NAME (Type) <b>Klaus H. Hubner M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-1-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East, Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>				ADDRESS <b>North East, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 11-30-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Joseph E. Rothman</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11802

Reg. Dist. No. 94

Items 3 & 13  
Film G-222 11/21/57.cac

Item 8 Film G-222 11-25-57 et  
Item 9 Film G-222 11-18-57 et

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East R.D.</b>				c. LENGTH OF STAY IN 1b <b>x2 Blkmills</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Susquehannah Flats</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George Andrew Anderson</b>				4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-4-1930</b>		9. AGE (In years last birthday) <b>27 2/3</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Gov. Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George Andrew Mann, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Margaret McCann</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Korean 219-28-3438</b>		17. INFORMANT <b>Geor A. Mann, Blkmills, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R. C. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>11-8-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>				24a. REC'D BY REGISTRAR <b>DATE 11-11-57</b>		24b. REGISTRAR'S SIGNATURE <b>Sarah E. Rothe</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11803

11800

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 4 mo. 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 306 F. Street, N. W.	
3. NAME OF DECEASED (Type or print) First JACOB I Middle J. Last MARAN		4. DATE OF DEATH Month November Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-89
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Photostat - Govt.	
11. BIRTHPLACE (State or foreign country) Turkey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Maran		14. MOTHER'S MAIDEN NAME Hazel ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 578-46-8391	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350x Strangulation due to foreign substance (metamucil) DUE TO (b) Paralysis agitans, severe (clinical) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe - unknown			INTERVAL BETWEEN ONSET AND DEATH 20 minutes unknown 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1957 to November 29, 1957, and that death occurred at 10:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE STATED ABOVE ACTUAL SIGNATURE S. P. LACERVA M.D. V.A. Hospital, Perry Point, Md. 12-4-57 PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 12-4-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE 12-6-57	
24b. REGISTRAR'S SIGNATURE			



CERTIFICATE OF DEATH

NAME OF DECEASED JAMES M. JONES		SEX Male		AGE 35	
DATE OF DEATH Dec 9, 1957		PLACE OF DEATH Baltimore, Md.		COUNTY Baltimore	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Nov 15, 1922		SEX AT BIRTH Male	
OCCUPATION Salesman		EDUCATION High School		RELIGION Catholic	
MARITAL STATUS Married		DATE OF MARRIAGE 1945		NAME OF SPOUSE Mary Jones	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF HOSPITAL St. Joseph's Hospital		NAME OF NURSE Mrs. J. K. Brown	
NAME OF CORONER Mr. J. L. Green		NAME OF JURY None		NAME OF WITNESS None	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF CORONER J. L. Green		SIGNATURE OF WITNESS None	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11804

## 11801 CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u>				c. LENGTH OF STAY IN 1b <u>24 yrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12-Charlestown</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H. Marquis</u> Last <u>-</u>				4. DATE OF DEATH Month <u>11/30/57</u> Day <u>19</u> Year <u>19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/4/1872</u>	
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Exilton Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm. Marquis</u>				14. MOTHER'S MAIDEN NAME <u>Bella Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mrs. Alva S. Marquis Charlestown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE (PULMONARY EMBOL)</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CIRRHOSIS OF LIVER</u> DUE TO (c) <u>-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>35</u> 19 <u>57</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/18</u> , 19 <u>57</u> , to <u>11/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/25</u> , 19 <u>57</u> , and that death occurred at <u>5:15</u> AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>J. Sandell Ross</u> M.D. <u>200 N. Union Ave</u>				<u>12-2-57</u>			
PHYSICIAN'S NAME (Type) <u>J. Sandell Ross</u>				<u>Have De House, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/3/57</u>		<u>Charlestown</u>		<u>Charlestown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Forrest J. Hande</u>				ADDRESS <u>Charlestown</u>		24a. REC'D BY REGISTRAR <u>12-2-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>			

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BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11802 CERTIFICATE OF DEATH

11805

Reg. Dist. No. 90

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HACKS POINT Cecilville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HACKS POINT Cecilville</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>H</u> Last <u>MAY</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph May</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-14-674</u>	
17. INFORMANT <u>Clara R May Cecilville MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>years.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple pulmonary emboli, 2 recent Cerebro vascular accident.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>21 Nov.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>21 Nov</u> , 19 <u>57</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Churnin</u> M.D.		DATE SIGNED <u>25 NOV 57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Nov 26 1957</u>	<u>Cecilville</u>	<u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Clauer</u>		24. REGISTRAR'S SIGNATURE <u>Mrs. Ralph R. Rees</u>	
ADDRESS <u>Millington</u>		DATE <u>Nov 26 1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED



11803

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo, R.D.</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James G Miller</u>				4. DATE OF DEATH Month Day Year <u>11-22-57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-1890</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Thaxton, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Washington Miller</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Myrtle Miller, Conowingo, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		<u>11-22-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stags Creek Cem</u>		22d. LOCATION (City, town, or county) (State) <u>West Jefferson N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson, Rising Sun, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 25 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

NOV 25 1957

BUREAU V. S.

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TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11807

11804  
CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 2.2.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside 02X0.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last NICK		4. DATE OF DEATH Month November Day 5 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-1899
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY Oysterman	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Nick		14. MOTHER'S MAIDEN NAME Annie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 216-16-4120	
(If yes, give war or dates of service) WW I		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Tuberculosis of right lung, far advanced, active DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 Thrombophlebitis of Iliofemoral veins - 5 days 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 21, 1957, to November 5, 1957, that I last saw the deceased at 2:32 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE S. P. LACERVA M.D. V.A. Hospital, Perry Point, Md. 11-6-57 PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-6-57	
22c. NAME OF CEMETERY OR CREMATORY St. Matthews' Cemetery		22d. LOCATION (City, town, or county) (State) Shady Side, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hibbs		24a. REC'D BY REGISTRAR DATE 10/2/57	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11808

11805

Reg. Dist. No. 91

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 4714n Kernwood Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Willard Clifton Pierce, Sr.				4. DATE OF DEATH Month Day Year 11 18 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-1902		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto. Executive		10b. KIND OF BUSINESS OR INDUSTRY Auto Sales		11. BIRTHPLACE (State or foreign country) Auburn, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME P Arthur E. Pierce				14. MOTHER'S MAIDEN NAME Margaret Cramer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.2		16. SOCIAL SECURITY NO. 216-09-4167		17. INFORMANT Willard C. Pierce, Jr. Address 1424 Dartmouth Baltimore			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest and Internal Injuries 978X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped from Chesapeake City Bridge Md					
20c. TIME OF INJURY Month, Day, Year 11 18 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake City Chesapeake City Cecil		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-19-57	
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/22/57		22c. NAME OF CEMETERY OR CREMATORY Wood lawn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Donald M. Bee Elkton, Md				24a. REG'D BY REGISTRAR DATE Nov 19		24b. REGISTRAR'S SIGNATURE Mrs. Ralph H. Thompson	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 21 1957

RECEIVED

MEDICAL CERTIFICATION

BUREAU V. S.

NOV 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G223 12-3-57 et

11777

CERTIFICATE OF DEATH

11811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>2-weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Reynolds</u> Last <u>Reynolds</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Reynolds</u>		14. MOTHER'S MAIDEN NAME <u>Anna Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-360003</u>	
17. INFORMANT <u>Mrs. Rebecca Reynolds</u>		Address <u>Rising Sun Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign prostatic hypertrophy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/9</u> , 19 <u>57</u> , to <u>11/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/23</u> , 19 <u>57</u> , and that death occurred at <u>3:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John A. Fischer</u> M.D.		ADDRESS (Street, city or town, state) <u>162 W. MAIN ST.,</u> DATE SIGNED <u>11/24/57</u>	
PHYSICIAN'S NAME (Type) <u>John A. Fischer</u>		<u>ELKTON, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 27, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Coleman, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>		ADDRESS <u>Rising Sun, Md.</u> DATE <u>NOV 27 1957</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>J. R. Rogers</u>	

CERTIFICATE OF DEATH

See this for

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1912	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
NOV 27 1957		BALTIMORE, MARYLAND		10:00 PM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
NOV 27 1957		NOV 27 1957		NOV 27 1957		NOV 27 1957	

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NOV 27 1957  
BUREAU V. B.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11812

## CERTIFICATE OF DEATH

Reg. Dist. No.

11778

Item 1, See: Birth Cert. et

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b> <b>X 2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Rifley</b> Middle <b>Rifley</b> Last <b>Rifley</b>		4. DATE OF DEATH Month <b>11</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-26-57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Blaine Perry</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Jane Rifley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Nancy J. Rifley Port Depoist, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atlectasis left lung.</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>11-26-57</b> , 19 <b>57</b> , to <b>11-26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-26</b> , 19 <b>57</b> , and that death occurred at <b>4:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. C. Dodson</b>		ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b> DATE SIGNED <b>11-27-57</b>	
PHYSICIAN'S NAME (Type) <b>R. C. Dodson</b>		ADDRESS <b>Rising Sun, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>12/4/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>	22d. LOCATION (City, town, or county) (State) <b>Colora md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M Reed, Rising Sun md</b>		24a. REC'D BY REGISTRAR <b>DEC 6 1957</b> 24b. REGISTRAR'S SIGNATURE <b>J. H. Frey</b>	

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11813
11806										MEDICAL EXAMINER'S CERTIFICATE OF DEATH
										Reg. Dist. No. 90
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City			c. LENGTH OF STAY IN 1b all life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Benjamin Wilson First Middle Last Ross					4. DATE OF DEATH Month 11 Day 20 Year 19 57					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Dec. 27-1912.		9. AGE (In years last birthday) 44 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY all kinds of work			11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benjamin F. Ross					14. MOTHER'S MAIDEN NAME Florence P. Forsythe					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 220-30-2686		17. INFORMANT Address Eleanor Inslo. Chesapeake City. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung himself with a rope over a beam							
20c. TIME OF INJURY Month, Day, Year Hour 10 m. 11 20 57			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage		20f. (City or town) (County) (State) Chesapeake City Cecil Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 11-23-57		22c. NAME OF CEMETERY OR CREMATORY Bethel Cem.		22d. LOCATION (City, town, or county) (State) Chesapeake City Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hellows, Millington, Md.					24a. REC'D BY REGISTRAR DATE NOV 25 1957		24b. REGISTRAR'S SIGNATURE Mrs. Ralph Russ			

NAVY AND STATE DEPARTMENT OF HEALTH - BATTLE CREEK 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

BUREAU V. S.

NOV 25 1957

RECEIVED

# CERTIFICATE OF DEATH

Reg. Dist. No.

11779

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp.</u>		d. STREET ADDRESS <u>1 Main St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Naomi</u> Last <u>Rouse</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10 1916</u>
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Chesapeake City Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Carter</u>		14. MOTHER'S MAIDEN NAME <u>Ida Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Chas Rouse Chesapeake City, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Hypertensive Cardio-Vascular disease</u> <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 31, 1957</u> , to <u>Nov 2, 1957</u> , that I last saw the deceased alive on <u>Nov 2, 1957</u> , and that death occurred at <u>4:10</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Oberstein</u> M.D. <u>Cecilton, Md</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3 Nov 57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Bohemian Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Hoppin</u> ADDRESS <u>Cecilton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>Nov 6</u>	
24b. REGISTRAR'S SIGNATURE <u>H. H. Hager</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1957 4 Nov.

BUREAU V. S.

CELESTIAL

62 448 171 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11815

96

## CERTIFICATE OF DEATH

Reg. Dist. No.

11807

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>		c. LENGTH OF STAY IN 1b <b>4 Mon. 6Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		301-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>333 N. Charles Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First Larry Middle E. Last Shaffer</b>		4. DATE OF DEATH <b>Month 11 Day 17 Year 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-13-87</b>
9. AGE (In years birth day) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman (Cash Registers)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Shaffer</b>		14. MOTHER'S MAIDEN NAME <b>Laura Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>219-07-4598</b>	
17. INFORMANT <b>Hospital Records, VA Hospital, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage non-traumatic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-12-</b> , 19 <b>57</b> , to <b>11-17</b> , 19 <b>57</b> , and that death occurred at <b>7:00 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>S.P. LACERVA</b> M.D. <b>V.A. Hospital, Perry Point, Md. 11-18-57</b> PHYSICIAN'S NAME (Type) <b>S.P. LACERVA, M.D., Director Professional Services, VA Hospital, Perry Point, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-18-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stewart &amp; Mowen Fun.Home, 108 W. North Ave. Baltimore Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 19 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Jane Dougherty</b>	

BUREAU V. S.

NOV 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11808

## CERTIFICATE OF DEATH

11816

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Confluence</b> 75 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Page Street</b>	
3. NAME OF DECEASED (Type or print) First <b>CARL</b> Middle <b>E.</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>11</b> Day <b>24</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11-21-11</b>
9a. AGE (In years last birthday) <b>46</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry E. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Mary Matthews</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>192-09-4223</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Peritonitis, due to Extravasated contents of Viscera</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4 To 5 Days</b> <b>10 To 12 Days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-31-45</b> , 19____, to <b>11-24-</b> , 19 <b>57</b> <del>XXXXXXXXXXXXXXXXXXXX</del> <del>XXXXXXXXXXXXXXXXXXXX</del> , and that death occurred at <b>8:20A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Perry Point, Md.</b> DATE SIGNED <b>11-24-57</b> ACTUAL SIGNATURE <b>E. S. Ellis</b> M.D. <b>Perry Point, Md.</b> PHYSICIAN'S NAME (Type) <b>E. S. ELLS, M.D., Acting Director, Professional Services, VAH, Perry Point, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-24-57 Removal</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Addison Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Addison, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		ADDRESS <b>Bayre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>11-29-57</b>		24b. REGISTRAR'S SIGNATURE <b>Irene E. Dougherty</b>	

BUREAU V. S.

DEC 2 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11809

CERTIFICATE OF DEATH

Reg. Dist. No.

11817  
96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 222</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Smith</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>14</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-1880</b>
9. AGE (In years birth day) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moulder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stove Foundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Louisa Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>216-07-2052</b>	
17. INFORMANT <b>Mrs Carrie Smith, Perryville, Md. Rural</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>523.0</b> IMMEDIATE CAUSE (a) <b>Chronic Silicosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>14 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 13, 1942</b> to <b>Nov 13, 1957</b> , that I last saw the deceased alive on <b>Nov 13, 1957</b> , and that death occurred at <b>12:34 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. I. Benson</b>		M.D. <b>Port Deposit, Md.</b> DATE SIGNED <b>11/15/57</b>	
PHYSICIAN'S NAME (Type) <b>C. I. Benson M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-16-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee a. Patterson &amp; Son</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>11-16-57</b>		24b. REGISTRAR'S SIGNATURE <b>Inene E. Dougherty</b>	

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559-70-81

Mrs. Carrie Smith, Perryville, Md. Rural

BUREAU A. S.

NOV 19 1957

RECEIVED

U. S. DEPARTMENT OF AGRICULTURE

Reynoldsville Mo.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11819

11780

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>0</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 North East, R.D.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital, D.O.A.</u>				d. STREET ADDRESS <u>Princess Ann Trailer Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Leo</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-1902</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air port</u>		11. BIRTHPLACE (State or foreign country) <u>Rock M. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Irvin Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Hanna Foster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>232-12-7163</u>		17. INFORMANT <u>Mrs. Lieby North East Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-10-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Pising Sun, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>				ADDRESS <u>Pising Sun, Md.</u>		24a. REC'D BY REGISTRAR <u>13 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>R. N. Snyder</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

DECEASED

1957

DATE OF DEATH

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1957

TIME OF DEATH

11:00 A.M.

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BUREAU V. 3

NOV 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11820

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, DC b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 1 year-4days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 21		16 x 2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VA Hospital, Perry Point, Md.		d. STREET ADDRESS 114 Seneca Dr. SE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Aage (NMI) Westergaard		4. DATE OF DEATH Month Day Year November 4 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-73
9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Ice Plant	
11. BIRTHPLACE (State or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anders Westergaard		14. MOTHER'S MAIDEN NAME Hedvig Nielsen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. Not ascertainable	
17. INFORMANT Address VAH, Perry Point, Md. (Hospital Records)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181X Pyelonephritis right, organism unknown, due to obstruction DUE TO (b) Papillary carcinoma of the bladder DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-30-19 56, to 11-4-57, and that death occurred at 6:55 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE E. S. Ellis, M.D.		VA Hospital, Perry Point, Md. 11-5-57	
PHYSICIAN'S NAME (Type) E. S. Ellis, M.D.		Actg. Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 11-5-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Remington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 11-5-57	
24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			



# CERTIFICATE OF DEATH

MD 200-100-100

BUREAU V. 2

NOV 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register of prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11822

11811

## CERTIFICATE OF DEATH

Reg. Dist. No.

91

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b 2 Weeks 21	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgans Nursing Home		d. STREET ADDRESS McCool Apts North St.	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha L. White		4. DATE OF DEATH Month 11 Day 19 Year 19 57	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 1 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Clerk		10b. KIND OF BUSINESS OR INDUSTRY Kennard Pyle Co Wilmington, Del.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clinton Johnson White		14. MOTHER'S MAIDEN NAME Martha Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Tobe Rudolph 515 North St Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Thrombosis. DUE TO (b) Cerebral Arteriosclerosis. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bed fast for years. Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 Nov, 19 57, to 19 Nov, 19 57, that I last saw the deceased alive on 19 Nov, 19 57, and that death occurred at 1 14 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Olenstein M.D.		ADDRESS (Street, city or town, state) Cecilton Md. DATE SIGNED 20 Nov 57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/22/57	
22c. NAME OF CEMETERY OR CREMATORY Honewell Cemetery		22d. LOCATION (City, town, or county) (State) Honewell, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Walter du Bone		ADDRESS ELKTON, Md.	
24a. REG'D BY REGISTRAR DATE Nov 23, 1957		24b. REGISTRAR'S SIGNATURE Mrs. Ralph Neep	

**BUREAU A. S.**

DEC 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11821

11781

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>One day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION, ELKTON, MD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Willard</u> Middle <u>Grafton</u> Last <u>Wharton</u>		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7.9.27</u>
9. AGE (In years lost birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months <u>30</u> Days <u>10</u> Hours <u>19</u> Min. <u>57</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FIRE BRICK</u>	
11. BIRTHPLACE (State or foreign country) <u>North East, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry Wharton</u>		14. MOTHER'S MAIDEN NAME <u>Carole Bryan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-20-5873</u>	
17. INFORMANT <u>Mrs. Camie Wharton</u>		Address <u>North East, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X</u> DUE TO <u>ACUTE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOPNEUMONIA</u> DUE TO (c) <u>RHEUMATIC HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>23 hours</u> <u>5 days</u> <u>14 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible</u> <u>SUBACUTE BACTERIAL ENDOCARDITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11.9</u> , 19 <u>57</u> , to <u>11.10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11.10</u> , 19 <u>57</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter Stavrakis</u> M.D.		DATE SIGNED <u>Nov. 10 57</u>	
PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS</u>		<u>ELKTON, Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11-13-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>North East Cecil, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Thant</u> ADDRESS <u>North East Md</u>		24a. REC'D BY REGISTRAR <u>Nov 13</u> DATE	24b. REGISTRAR'S SIGNATURE <u>JR Frazer</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11812 CERTIFICATE OF DEATH

11823

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EMORY</b> Middle <b>PATTERSON</b> Last <b>WYRE Sr.</b>				4. DATE OF DEATH Month <b>11</b> Day <b>2</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-5-1905</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mixer Triumph Explosives</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fireworks</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Wyre</b>				14. MOTHER'S MAIDEN NAME <b>Anna Alexander</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>213-05-4645</b>		17. INFORMANT Address <b>Mrs Madeline Myre North East, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241X Uremia</b> DUE TO <b>Generalized cardiac hypertrophy and dilatation with passive congestion of lungs, liver, kidneys.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Chronic bronchial asthma and pulmonary emphysema</b> (c) <b>14 yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gastric Ulcer - pre-pyloric</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>5 a. m.</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May</b> , 19 <b>46</b> , to <b>2 Nov</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1 Nov</b> , 19 <b>57</b> , and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Klaus H. Huebner</b> M.D.				ADDRESS (Street, city or town, state) <b>North East, Md</b> DATE SIGNED <b>3 Nov 57</b>			
PHYSICIAN'S NAME (Type) <b>Klaus H. Huebner M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-5-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East, Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R Grant</b> ADDRESS <b>North East, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>11-6-57</b>		24b. REGISTRAR'S SIGNATURE <b>Savala, E. Rothermel</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11824

11813

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Newark, Del.</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>405 Jackson Hall School Rd., Del.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Newark, Del. x/</b>			
d. STREET ADDRESS <b>Newark, Delaware</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Wildman</b> Last <b>Zebley</b>				4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1887</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Elwood Zebley</b>				14. MOTHER'S MAIDEN NAME <b>Georgeanna Wildman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>221-10-7949A</b>		17. INFORMANT <b>Mrs. Anna B. Zebley</b> Address <b>405 Jackson Hall School Rd. Newark, Delaware</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumothorax with mediastinal shift - about 2 yrs duration</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 3</b> , 19 <b>53</b> to <b>Nov. 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 10</b> , 19 <b>57</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b>				M.D. <b>233 E. Main Street</b>		DATE SIGNED <b>11/11/57</b>	
PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews, Jr., M.D.</b>				<b>Elkton, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Head of Christiansa</b>		22d. LOCATION (City, town, or county) (State) <b>Newark, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.T. Jones</b>				ADDRESS <b>Newark, Del.</b>		24a. REC'D BY REGISTRAR DATE <b>11/16/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>JR J. J. J.</b>			

# CERTIFICATE OF DEATH

Form No. 10

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1900	
Place of Birth		Race		Occupation		Cause of Death	
New York City		White		Teacher		Heart Disease	
Date of Death		Time of Death		Place of Death		Physician	
Nov 15, 1950		10:30 AM		Home		Dr. Smith	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	

Date of Death		Time of Death		Place of Death		Physician	
Nov 15, 1950		10:30 AM		Home		Dr. Smith	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

RECEIVED

NOV 15 1950